STATE OF MARYLAND

DHMH

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August 13, 2010

Public Health & Emergency Preparedness Bulletin: # 2010:31
Reporting for the week ending 08/07/10 (MMWR Week #31)

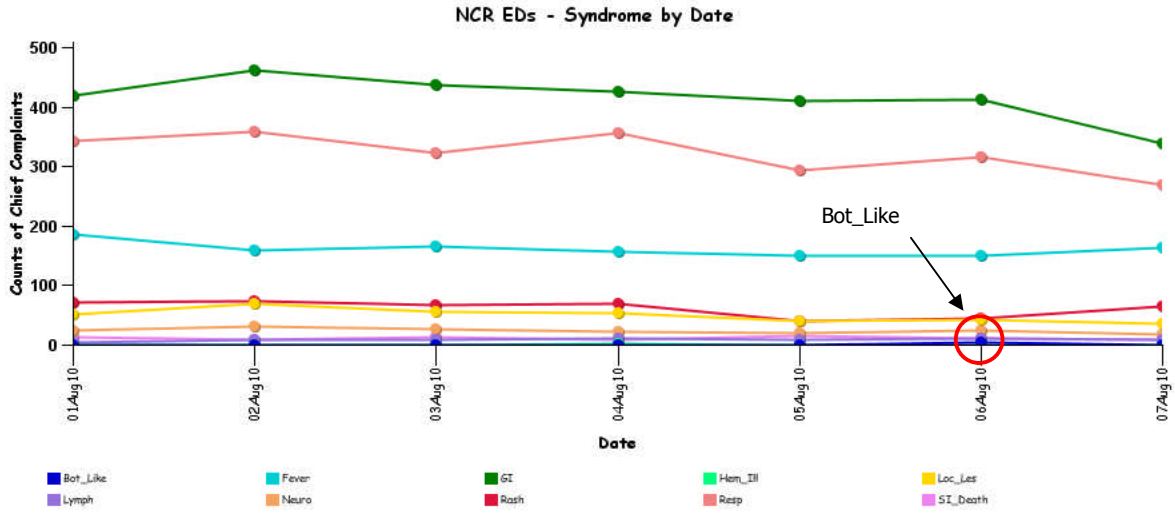
CURRENT HOMELAND SECURITY THREAT LEVELS

National: **Yellow (ELEVATED) *The threat level in the airline sector is Orange (HIGH)**
Maryland: **Yellow (ELEVATED)**

SYNDROMIC SURVEILLANCE REPORTS

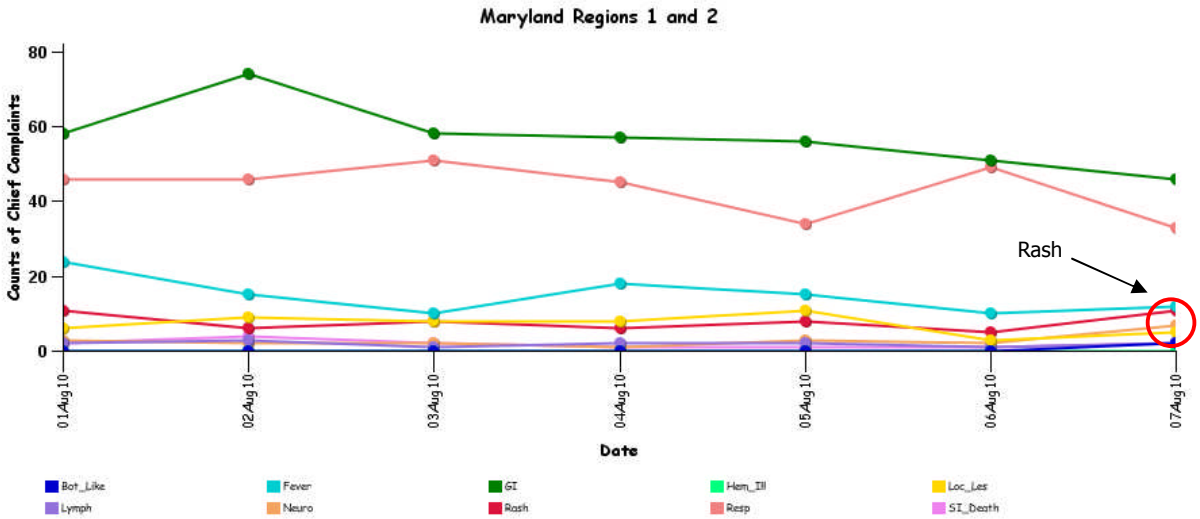
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR Spring 2006 (v 1.3) now uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

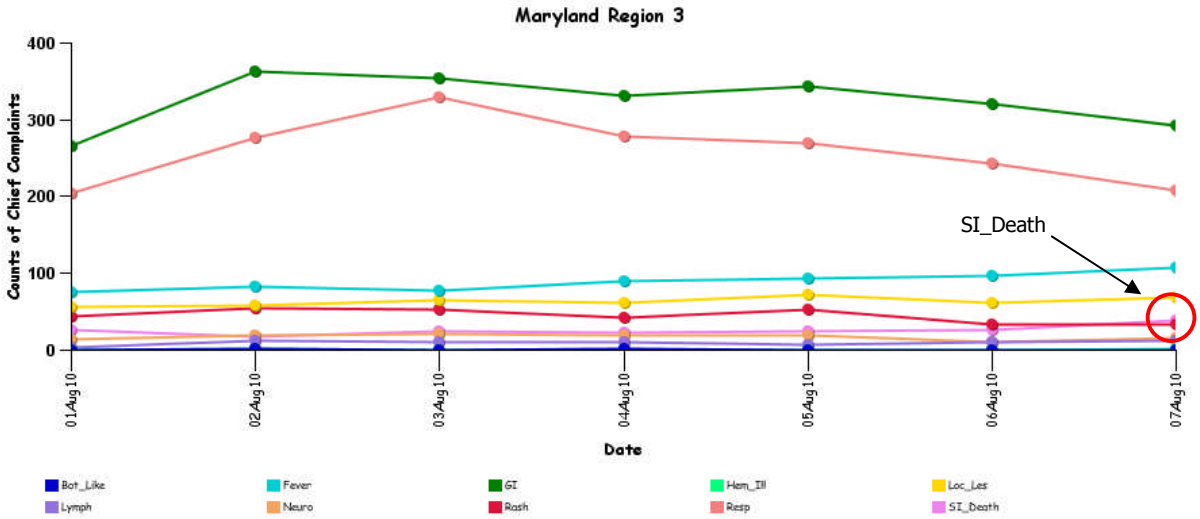


* Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

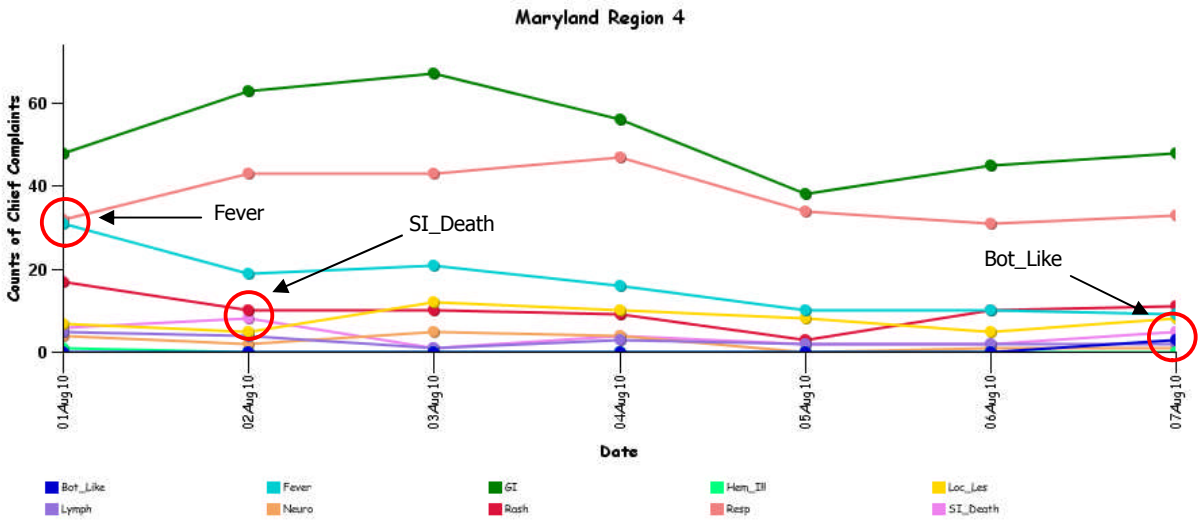
MARYLAND ESSENCE:



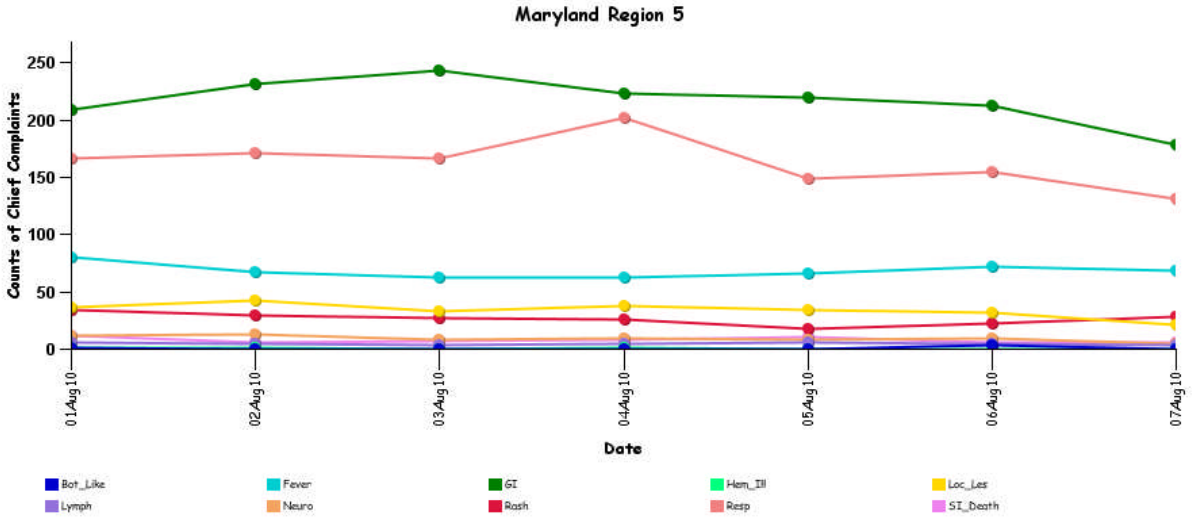
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore city, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



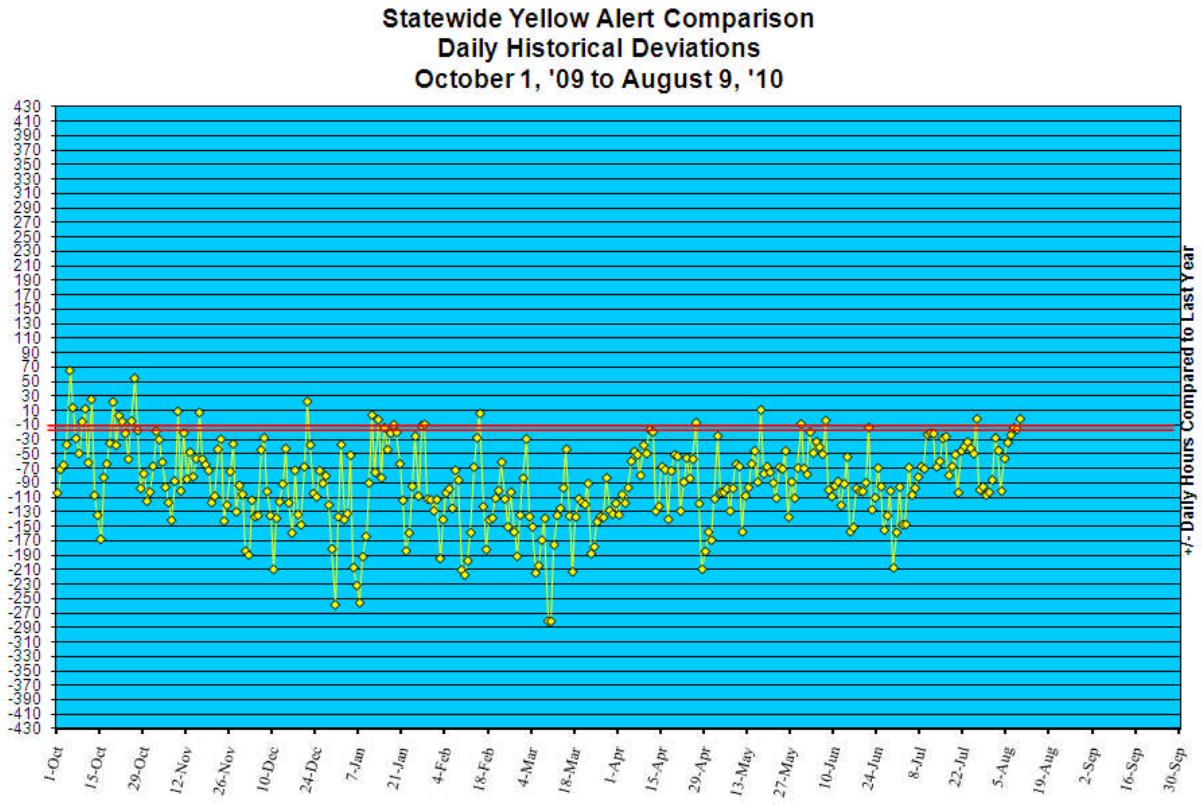
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/09.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in July 2010 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

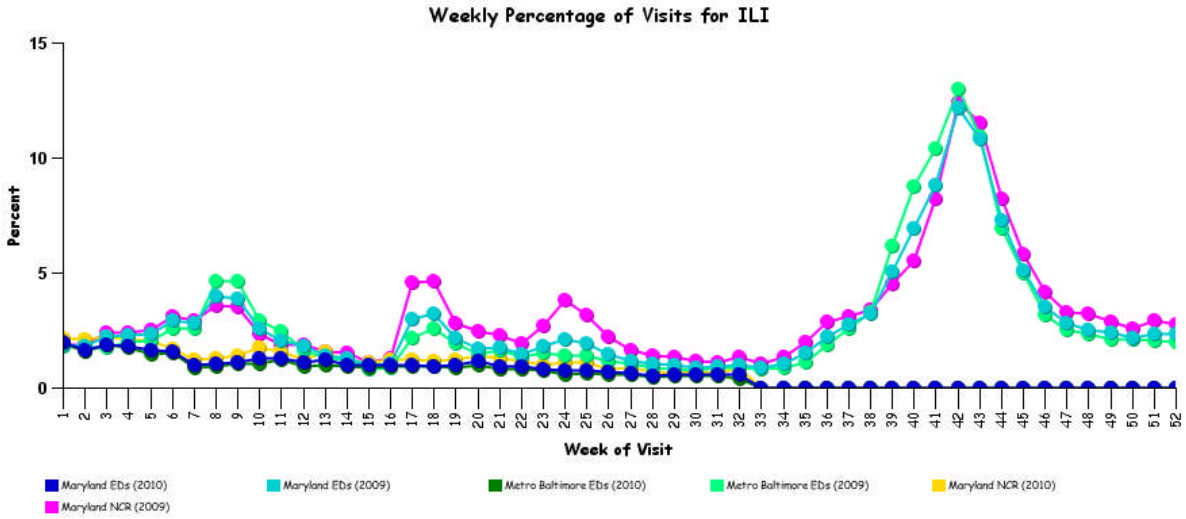
Meningitis:	**Aseptic**	**Meningococcal**
New cases (August 1 – August 7, 2010):	12	0
Prior cases (July 25 – July 31, 2010):	08	0
Week#31, 2009 (August 2 – August 8, 2009):	09	0

0 outbreaks were reported to DHMH during MMWR week 30 (July 25-July 31, 2010)

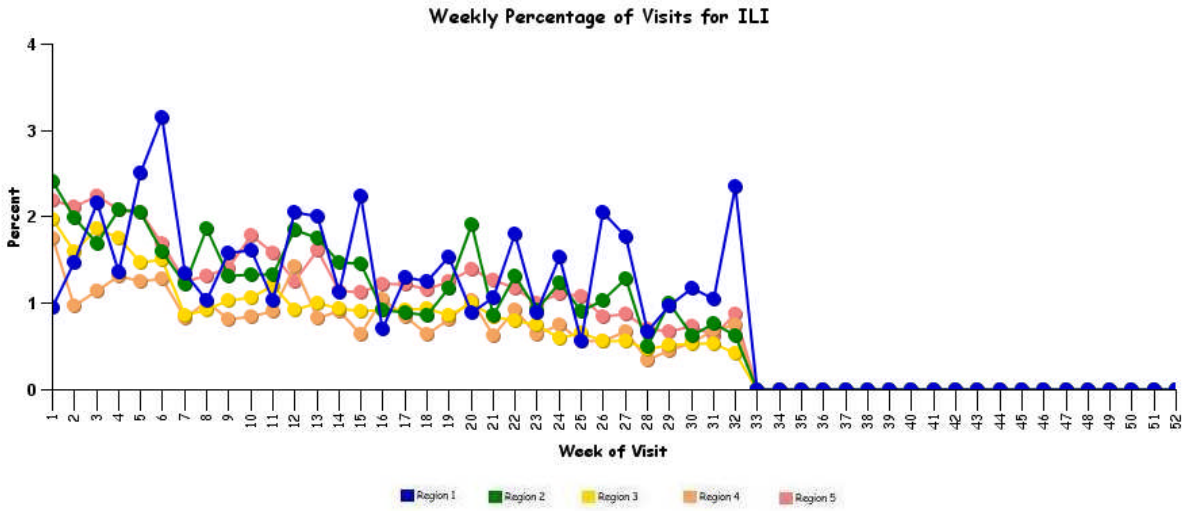
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



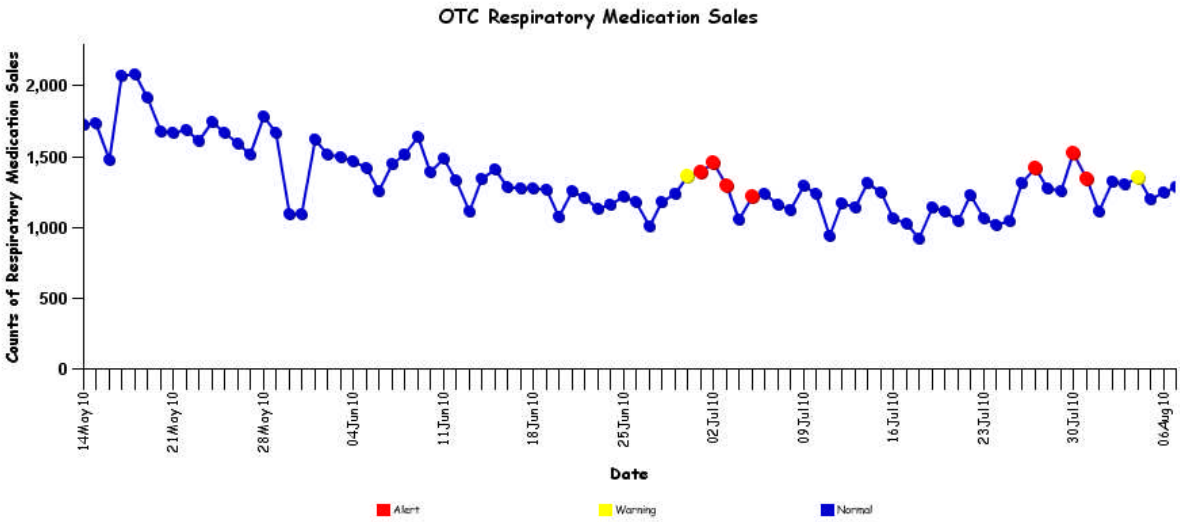
* Includes 2009 and 2010 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2010 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



AVIAN INFLUENZA-RELATED REPORTS:

WHO update: The current WHO phase of pandemic alert for avian influenza is 3.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

As of August 3, 2010, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 503, of which 299 have been fatal. Thus, the case fatality rate for human H5N1 is about 59%.

H1N1 INFLUENZA (Swine Flu):

INFLUENZA PANDEMIC (H1N1) WORLD HEALTH ORGANIZATION UPDATE: 7 August 2010, As of 1 Aug 2010, worldwide more than 214 countries and overseas territories or communities have reported laboratory confirmed cases of pandemic influenza H1N1 2009, including over 18 449 deaths. The WHO is actively monitoring the progress of the pandemic through frequent consultations with the WHO Regional Offices and member states and through monitoring of multiple sources of information.

The overall situation remains largely unchanged since the last update. Globally, pandemic influenza transmission remains most active in parts of South Asia and in limited areas of tropical South and Central America. In the temperate zone of the southern hemisphere, overall seasonal and pandemic influenza activity remains low, except in South Africa, where peak wintertime influenza transmission due to circulating seasonal influenza viruses (H3N2 and type B) might have recently occurred. Seasonal influenza viruses, particularly H3N2 viruses, continue to circulate in parts of Central America, East Africa, and Southeast Asia.

During the 2010 winter of the temperate southern hemisphere, the most active areas of influenza virus transmission have been in South Africa, where the majority of influenza virus detections have been seasonal influenza H3N2 and type B viruses; pandemic influenza virus has been detected there only sporadically. Elsewhere in Argentina, Chile, New Zealand, and Australia, overall influenza activity remains low and below levels observed during recent, mild, pre-pandemic influenza seasons; among the latter 3 countries, pandemic influenza viruses have been detected most frequently; however, low level co-circulation of seasonal influenza H3N2 and type B has also been observed.

In South Africa, the current wintertime epidemic of seasonal influenza appears to have peaked during early July 2010 and stabilized since then; to date, influenza type B viruses have accounted for a greater proportion of influenza viruses detected among severe (SARI) cases than have influenza H3N2 viruses. Chile and Argentina continue to observe low levels of respiratory diseases in the population, and much of what has been observed in recent months has been due to circulation of respiratory viruses other than

influenza, particularly RSV.

In Australia and New Zealand there has been a sustained upward trend in the rates of ILI over the past 6-8 weeks, particularly in recent weeks, however, overall rates remain well below those observed during the same period in 2009 during the 1st pandemic wave in the southern hemisphere. Data on the clinical and epidemiological pattern of pandemic influenza virus infection during the current winter season have been limited due to the fact that there has been limited virus transmission to date; however, preliminary data suggests that the pattern has not changed compared to what was seen last winter during the 1st pandemic wave in the southern hemisphere.

In Asia, the most active areas of pandemic influenza virus transmission currently are in parts of India, and to a much lesser extent, in parts of Nepal and Bhutan. Transmission appears to have peaked in the southern state of Kerala, while transmission remains moderately intense in the western state of Maharashtra, and may be increasing in several eastern states, including Orissa and West Bengal. Limited, preliminary data suggests that the overall intensity and severity of the current regional epidemics in India do not yet appear to exceed what was observed during the 1st wave in 2009; however, it is too early make a complete assessment of the situation as the regional epidemics are still evolving. Similarly, there has been no evidence to date to suggest that clinical and epidemiological pattern of pandemic influenza virus infection has changed during the current period of active transmission.

Overall, across India, approximately one quarter of respiratory samples tested positive for influenza as of 3rd week of July 2010; however, in at least one region of India, up to one 3rd of respiratory samples tested positive for influenza. In addition to the recent increases in circulation of pandemic influenza viruses in India, there has been, in recent months, active circulation of seasonal influenza type B viruses, and to a lesser extent, seasonal influenza H3N2 viruses. In neighboring Bangladesh, Bhutan, and Nepal, but not Sri Lanka, there is limited evidence of low levels of pandemic influenza virus transmission, including reports of localized outbreaks in Nepal and Bhutan. In Southeast Asia, low to sporadic levels of co-circulating pandemic and seasonal influenza viruses have been detected across the region over the past month.

In the tropical regions of the Americas, active subregional co-circulation of seasonal and pandemic influenza viruses continued to be detected during July 2010. Since early June 2010, predominantly seasonal influenza H3N2 viruses have circulated in Panama, Nicaragua, and Honduras; seasonal influenza B and more recently H3N2 viruses in El Salvador; and, predominantly pandemic influenza and H3N2 viruses in Costa Rica and Columbia.

In sub-Saharan Africa (excluding South Africa), Ghana continued to report sustained transmission of pandemic influenza virus during June and July 2010; during the most recent reporting week, 27 percent of respiratory samples tested positive for pandemic influenza virus. Limited data indicate that seasonal influenza H3N2 and B viruses continued to circulate at variable levels in parts of eastern Africa and central Africa, respectively. In Cameroon, a sustained period of active transmission of seasonal influenza B viruses, which began during early June 2010, now appears to be subsiding. In Kenya, there has been persistent low level circulation of seasonal H3N2 viruses since late April 2010.

In the temperate regions of the Northern hemisphere, pandemic and seasonal influenza viruses have been detected only sporadically or at very low levels during the past month. (Countries in temperate regions are defined as those north of the Tropic of Cancer or south of the Tropic of Capricorn, while countries in tropical regions are defined as those between these 2 latitudes.)

Resources:

http://www.cdc.gov/h1n1flu/

http://www.dhmh.maryland.gov/swineflu/

NATIONAL DISEASE REPORTS

SALMANELLOSIS, REPTILE FEED (USA): 06 July 2010, CDC is collaborating with public health officials in many states and the FDA to investigate a multistate outbreak of Salmonella infection, serotype I 4,[5],12:i:-. Investigators are using DNA analysis of Salmonella bacteria obtained through diagnostic testing to identify cases of illness that may be part of this outbreak. As of 9 pm EDT on 29 Jul 2010, a total of 34 individuals infected with a matching strain of Salmonella serotype I 4,[5],12:i:- have been reported from 17 states since 1 Jan 2010. The number of ill persons identified in each state with this strain is as follows: AL (1), AZ (1), CO (1), GA (7), IA (1), IL (3), MA (3), MI (1), MO (3), NC (3), NV (1), NY (2), SC (1), TN (1), VA (1), WI (3), and WY (1). Among the persons with reported illness onset dates available, illnesses began between 4 Dec 2009, and 9 Jun 2010. Infected individuals range in age from less than 1 to 57 years old and the median age is 12 years. 53 percent of patients are male. Among the 17 patients with available information, 1 (6 percent) was hospitalized. As of 29 Jul 2010, no deaths attributed to this infection have been reported. CDC and public health officials in multiple states are conducting an epidemiologic study. Preliminary analysis of this study has suggested an association with frozen rodents used for reptile feed. Ill persons (61 percent) were significantly more likely than well persons (0 percent) to report any exposure to rodents in the week before illness. Additionally, ill persons (26 percent) were significantly more likely than well persons (0 percent) to report using frozen rodents for reptile feed in the week before illness. An environmental investigation was conducted by the FDA, and culture of samples collected yielded Salmonella that matched the human outbreak strain. Although referred to differently in the USA and UK, the strain in the USA investigation is

indistinguishable from the strain that caused an outbreak in the United Kingdom in 2009. The outbreak investigation by the Health Protection Agency of the UK implicated frozen mice imported from the USA as food for pet reptiles as the source of human illness. (Food Safety Threats are listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS, RESTAURANT (COLORADO): 05 August 2010, The Fort restaurant in Jefferson County, where world leaders dined with President Bill Clinton during the G7 Summit in 1997, is the source of a recent salmonella outbreak, according to local health officials. Investigators with the Jefferson County health department reported 8 confirmed cases and 20 probable cases in which people became ill after dining at the well-known restaurant in the [Rocky Mountain] foothills, said Nancy Braden, a health department spokeswoman. The outbreak happened between 10 and 16 Jul 2010 and was triggered by dishes, including rattlesnake cakes, that included eggs. The restaurant specializes in wild game and Old West recipes. Jefferson County Health Department staff traced the cause of the illnesses to eggs that likely were undercooked. (Food Safety Threats are listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

LA CROSSE ENCEPHALITIS (MINNESOTA): 05 August 2010, A 6-year-old Caledonia, Minn., boy has become the year's 1st confirmed case of La Crosse encephalitis in the region. The onset of the mosquito-borne [virus] disease was reported 11 Jul [2010], and the boy was hospitalized in Rochester, Minn., until last week, said Dave Geske, La Crosse County Health Department mosquito control officer. Aedes or Ochlerotatus triseriatus, the mosquito that carries La Crosse encephalitis [virus; LACV], was found in water on a tarp and in open bins close to the boy's home, Geske said. The boy's home also is near a woodland area within 50 yards of traps set up by Geske's staff to catch mosquitoes, he said. "Houston and Winona counties are hotbeds for Ae triseriatus in Minnesota," Geske said. The risk for La Crosse encephalitis has increased this year, he said. As La Crosse endures its 3rd-wettest summer on record, "the potential is great for a bad encephalitis year," Geske said. "Anything that collects water outside is filled with water. ... Normally this time of the year, containers are dry," he said. [Basal tree holes in hardwood trees are protected and replenished by summer rains so usually retain water throughout the summer, and are ideal and very common breeding places for Ae triseriatus - Mod.TY] The La Crosse area averages 4-6 encephalitis cases every summer, with the peak months in August and September. La Crosse encephalitis affects the nervous system and causes acute inflammation of the brain, with a 5 to 20 percent death rate among children. [CDC reports that fatal cases are rare, less than 1 percent. Neurological sequelae in encephalitis survivors have been reported in some cases. - Mod.TY] While it's a bit early to have a 1st encephalitis case, Geske said he has seen June cases in past years. The 1st 2009 case came in mid-August. "The important thing now is to make sure anything, from traps to containers, needs to be emptied," Geske said. "We can't have water standing around." [Emptying water catchments near areas of human dwellings and activity is helpful, especially discarded tires. However, finding and emptying basal trees holes in extensive woodland areas is logistically impossible in this area. - Mod.TY] (Viral encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

CAMPYLOBACTERIOSIS (MONTANA): 04 August 2010, County and state health officials on Friday [30 Jul 2010] said several people have become ill after consuming water from a privately owned public water supply near Hebgen Lake. The Montana Department of Public Health and Human Services [DPHHS] has confirmed 14 cases of Campylobacter gastrointestinal illness, a common sickness, the Gallatin County Health Department said in a statement Friday morning [30 Jul 2010]. Information collected about the cases "strongly suggests that exposure occurred at the Campfire Lodge Resort," according to the statement. At least 70 more cases are considered "probable." Along with county health agents and DPHHS, the Montana Department of Environmental Quality, and Madison County Health Department are involved in the probe. "The good news is that we believe the likely source that has been causing these illnesses has been identified," Shelley Nolan of DEQ [Department of Environmental Quality] said in the statement. Gallatin County health officer Matt Kelley said the risk to public health is minimal because the likely source has been discovered. "We believe the risk to public health from a well at this particular establishment has been eliminated at this time...," he said. "The investigation will continue looking at all possible sources that might be causing this outbreak in order to ensure the public's safety." The owners of the resort are cooperating with the probe, and have taken action to prevent future illnesses, Kelley said in the statement. (Food Safety Threats are listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

LA CROSSE ENCEPHALITIS (MISSISSIPPI): 03 August 2010, A case of the mosquito-borne illness LaCrosse encephalitis has been reported in Montgomery County. The Mississippi State Department of Health says the illness is similar to West Nile virus [infection]. People [especially pre-school age children - Mod.TY] with LaCrosse encephalitis may have fever, headache, vomiting, lethargy and sometimes seizures. The department said Monday [2 Aug 2010] this is the 1st case of the illness reported in Mississippi since 2008. (Viral encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS

ENCEPHALITIS (GREECE): 06 August 2010, Cases of encephalitis possibly due to West Nile virus or other similar virus have been detected by the competent authorities in Central Macedonia, according to the Center for Disease Control and Prevention. They are taking preventive measures. Under KEELPNO [the Hellenic Centre for Diseases Control], 2 cases have been confirmed and 9 others are possible. The final documentation of the diagnosis is pending. The virus is transmitted only through the bite of infected mosquitoes and not from human to human. Many patients also mentioned by the KEELPNO have mild symptoms such as fever and muscle aches. Some patients do not exhibit any symptoms. A minimum figure of less than 1 percent in the mostly elderly and most vulnerable group have complications in the central nervous system, such as meningitis or encephalitis, but in most cases have a good course [of infection]. The Ministry of Health, in addition to measures for early detection and reporting of incidents, [have] in addition coordination with authorities. In addition, citizens [should] be using insect repellents and clothing that cover the widest possible area of the body (e.g., sleeves). Epidemics of West Nile virus have occurred since 1996 in EU (European Union) countries

and in the USA. This is the 1st outbreak in Greece. Outbreaks are associated with warming and population growth of mosquitoes. (Viral encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

PLAGUE (PERU): 05 August 2010, During Epidemiological Week (EW) 28 of 2010, the Ministry of Health of Peru confirmed the 1st case of pneumonic plague in a 29 year old patient from the district of Chocope, province of Ascope, department La Libertad. The presence of buboes had not been identified in the patient. Subsequently 3 more cases were registered. They were confirmed by rapid test. As of EW 30, 17 cases of plague have been reported; of these 4 are pneumonic plague, 12 are bubonic plague and 1 was septicemic plague which resulted in death. The onset of symptoms for the last pneumonic case was 11 Jul 2010. During the investigations, 10 isolates of Y. pestis were isolated from humans, rodents and domestic cats. The last plague outbreak reported in the province of Ascope occurred in the locality of Santa Clara, in the district of Casa Grande between August and September 2009. During the outbreak, 15 cases were reported, of which 9 cases were confirmed by laboratory. Among the current outbreak control measures carried out by the national and local authorities of Peru are:
- Active search for contacts and secondary cases; beginning of chemoprophylaxis use on the contacts;
- Strict monitoring of the implementation of biosafety measures by the health workers;
- Strengthening of the laboratory network for collecting and processing samples;
- Implementation of an environmental management program.
(Plague is listed in Category A on the CDC list of Critical Biological Agents) *Non-suspect case

UNDIAGNOSED ENCEPHALITIS (INDIA): 05 August 2010, Fears that Gujarat may soon face another viral outbreak have grown stronger. The state government revealed on Wednesday [4 Aug 2010] that acute viral encephalitis, an illness which causes swelling of the brain, had claimed 17 lives. Shockingly, of these, 11 people breathed their last on Tuesday [3 Aug 2010] alone. Alarmed by the high number of deaths in a day, the state health department has sent emergency medical teams to Vadodara, Kheda, and Panchmahal -- the 3 districts where all the 17 deaths have occurred. "We have sent rapid action teams to the affected regions," State health minister Jay Narayan Vyas told Mirror. "Every necessary step will be taken to prevent the outbreak of the disease." He also said that so far 29 people had tested positive for viral encephalitis. [The tests employed are not specified, nor specific viruses implicated. - Mod.TY] Till Tuesday [3 Aug 2010], this figure was 16. "We have sent samples of suspected cases to National Institute of Virology in Pune. Once we receive the reports, we will prepare an action plan (to deal with the situation)," he said. Of the 17 deaths in Gujarat, 9 have been reported in Panchmahal, 6 in Kheda, and 2 in Vadodara. The 3 districts seem to be in the grip of viral encephalitis as they also account for all the positive cases so far. Sources in the health department said one could contract the disease through many ways. However, in the current situation, sand fly appears to be spreading the infection. Though the number of positive cases is not that high at present, there is still a lot of concern among health authorities. This is because more than 36 000 people in the state, including 2006 in Ahmedabad, are suffering from a "fever of unknown origin" (FUO). There are fears that a significant number of these people may have contracted viral encephalitis. Encephalitis is caused mostly by a viral infection, which can be contracted through insect bites, food, drink, or contact with an infected person. Once the virus enters the bloodstream, it localises the brain, forcing white blood cells to invade the brain issue to battle the infection. This results in swelling of the brain. The disease can cause nerve damage, permanent impairment, and even death if there is a delay in treatment. Fever, headaches, clumsiness, drowsiness, vomiting, and convulsions are among the symptoms related to the illness. The elderly, infants, and HIV patients are the most at risk. Though the acute phase of viral encephalitis lasts for a couple of weeks, some people may take several months to recover. "The percentage of children testing positive is high. They have high fever and suffer from convulsions. There are also instances where affected people have gone into comma," Vyas said. He said people who show symptoms of encephalitis should be hospitalised immediately. "If an infected person is not put under immediate medical observation, the chances of his/her condition becoming acute increase sharply," the health minister said. On the carrier of the infection, he said that sandflies were mostly found in mud houses. "They enter through cracks in the walls," he said. (Viral encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

JAPANESE ENCEPHALITIS AND OTHER (INDIA): 05 August 2010, Japanese encephalitis [JE] which broke out for the 1st time in Nalbari district has so far claimed one life at Barkuriha village under Barbhag Revenue circle. The deceased was aged about 74. He was admitted to Gauhati Medical College Hospital (GMCH) with high fever where he was diagnosed with Japanese encephalitis. One more patient from the village is undergoing treatment at the hospital. The surfacing of his fatal disease has created panic among the people of these areas. The people have alleged that the District Health Department has taken no serious steps to combat it. The district malaria department sprayed DDT only among 4 families. The district malaria officer opined that as the area is not included in the action plan for spraying DDT, they have no right to spray DDT without the permission of the higher authority. On the other hand the district health department, though, sent a bugging vehicle to the affected village but it miserably failed to discharge smoke due to some mechanical defect. Even, the deputy commissioner of Nalbari who is the president of district health society or the joint director of health services is yet to visit the affected village, which is situated only 8 km [5 mi] away from Nalbari town. The panic stricken villagers on Sunday [1 Aug 2010] organised an awareness meeting at Barkuriha LP school inviting health and malaria officials. The awareness meeting presided over by Dr Biren Deka was addressed among others by Dr Kamal Dev Goswami, health officer of Kamarkuchi PHC [primary health care], Dr Gokul Patowary, IDS [India Development Service], Nalbari, Dipak Tamuli, district malaria officer, Rajib Sarma, media expert NRHM [National Rural Health Mission], and Ashok Kalita, panchayat [village assembly] president. The panicky villagers demanded the health department to immediately administer Japanese encephalitis [virus] vaccine in the village. They also demanded the district administration to shift the piggery farm, the source of this virus, to a areas away from inhabited places. (Viral encephalitis is listed in Category B on the CDC list of Critical Biological Agents) *Non-suspect case

ANTHRAX, HUMAN, EQUINE (RUSSIA): 05 August 2010, One man died and 5 others were hospitalized after contracting anthrax at a farm in the Omsk region that supplied horse meat for pelmeni sold in Moscow and other regions, Interfax reported Monday [3 Aug 2010]. All 6 victims fell ill after being hired to cut meat from diseased animals, said Gennady Onishchenko, head of

the Federal Consumer Protection Service. Horses started dying at the farm in June [2010], but the farm's owners hid the deaths, he said. Lifenews.ru said about 2.5 tons of horse meat with anthrax were supplied to Darina, a prominent pelmeni producer. The meat was confiscated, as were shipments of the company's pelmeni in the Moscow, Omsk, Tyumen, Sverdlovsk, and Tver regions, the Novy Region news agency reported. (Anthrax is listed in Category A on the CDC list of Critical Biological Agents) *Non-suspect case

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: www.tinyurl.com/flu-enroll

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

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